DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 08/09/2011 FORM APPROVED OMB NO. 0938-0391

	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING			COMPLETED 07/15/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2335 NORTH MADISON AVENUE ANDERSON, IN46011					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	D BE	(X5) COMPLETION DATE	
R0000	Complaint IN000 State residential: allegations are cire R349. Survey date: July Facility number: Provider number AIM number: Note and Mankell, Census bed type: Residential: 58 Total: 58 Census payor type Medicaid: 24 Other: 34 Total: 58 Sample: 3 These state reside in accordance with the state residential and the state reside in accordance with the state reside in accordance with the state residential and the state reside in accordance with the state residential and the state residential and the state residential and the state residential and the state residential allegations are circles. The state residential allegations are circles and circles are circles and circles are circles ar	093520 - Substantiated. findings related to the ted at R052, R214, and y 15, 2011 010409 :: 010409 /A R.N.	RO	0000	Submission of the plan of correction does not constadmission to or agreemed Keystone Woods Assisted Community with the allest found on this survey. Sure of this plan of correction matter of regulatory community of the community	stitute an ent by ed Living ged facts ubmission is a		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QJSY11

Facility ID:

010409

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMP: 07/15/2	LETED	
	PROVIDER OR SUPPLIER		STREET 2335 N	ADDRESS, CITY, STATE, ZIP CO NORTH MADISON AVEN RSON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
R0052	(1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punish (5) neglect; and (6) involuntary sec Based on record interview, the fac cognitively impa independently an neglect and supe ensured when the facility onto the facility. This residents in a san diagnosis who w facility for 6 hou and B). Findings include 1. On 7/15/11 at entrance intervie she indicated the residents in the fa there were reside there were none leave the facility were two residen wife (Residents A the building and return due to the	clusion. review, observation, and cility failed to ensure ired residents, who were inbulatory, were free from revised in a manner that ey went outside of the facility grounds ey were able to re-enter practice affected 2 of 3 inple of 3 with a dementia ere locked out of the rs at night. (Residents A	R0052	R0052 WHAT CORR ACTION(S) WILL BE ACCOMPLISHED FO RESIDENTS FOUND BEEN AFFECTED B' DEFICIENT PRACTI policy for when to loc was changed on 07/2 8pm to 10pm. This w for residents going ou front porch during da to do so without bein out. A sign was post of the doors directing use the after-hours p to the side of each do staff to come and ope on 07/11/2011. Both & B had mental statu questionnaires comp 08/02/2011 to determ are appropriate to rer independent setting. FACILITY WILL IDEN OTHER RESIDENTS THE POTENTIAL TO AFFECTED BY THE DEFICIENT PRACTI WHAT CORRECTIVE WILL BE TAKEN: The when to lock the door changed on 07/11/20 to 10pm. A sign was each of the doors dir persons to use the af	DR THOSE DR THOSE DR THOSE D TO HAVE Y THE CE: The ck the doors 11/2011 from vould allow utside on the ylight hours g locked ed on each persons to hone located por, to notify en the door residents A s leted on hine if they main in an HOW THE NTIFY S HAVING D BE SAME CE AND E ACTION e policy for rs was 11 from 8pm posted on ecting	08/05/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2335 NORTH MADISON AVENUE KEYSTONE WOODS ANDERSON, IN46011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE would leave the building at will and walk phone to notify staff to come and open the door on 07/11/2011. All on the grounds or sit on the front porch. residents with a dementia She said they were not monitored as they diagnosis had mental status were independent and didn't need to be questionnaires completed on monitored. She said if they needed 08/02/2011 to determine if they are appropriate to remain in an assistance, Resident A, the husband, independent setting. WHAT would go up to the nurses and ask for help MEASURES WILL BE PUT INTO for himself or his wife. She said they had PLACE OR WHAT SYSTEMIC a pendent call button, but they didn't use CHANGES THE FACILITY WILL MAKE TO ENSURE THAT THE it. She said Residents A and B had left the DEFICIENT PRACTICE DOES building and couldn't return one night as NOT RECUR: The policy for the doors were locked, but the facility had when to lock the doors was since left the doors unlocked until 10:00 changed on 07/11/2011 from 8pm to 10pm. A sign was posted on P.M. She thought they had gone outside each of the doors directing because it was still light out at 9:00 P.M. persons to use the after-hours She further indicated the only way she phone to notify staff to come and knew what had happened was by open the door on 07/11/2011. The pre-screening process will watching the video from the camera at the include the mental status front entrance. She indicated this camera questionnaire to determine if was not able to be seen on the monitor in potential new residents with the nurses' station, but she was able to cognitive impairments are appropriate for an independent view it on another monitor that she could setting. The nursing staff were access. She said Resident A had pulled informed of the policy to change the gliders into the area between the two the time to lock the doors, and sets of front doors and the residents had who is responsible to lock the doors, plus reminded of the policy attempted to sleep there. She said revision to check the front Resident A appeared to have a flip phone, entrance every 2 hours during the which he attempted to use, but was unable hours of 10p-6am on 07/11/2011. to do so. She indicated he could be seen The nurses were reminded on 08/03/2011 of the policy change hitting the front door. She indicated there regarding what time to lock the was a phone on the wall with instructions doors and who is responsible to on the number to call at the nurses' lock the doors, plus reminded of station, but he didn't attempt to call the the policy revision to check the front entrance every 2 hours nurses' station. Facility ID:

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Event ID:

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010409

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED		
			B. WIN			07/15/2	011	
NAME OF	PROVIDER OR SUPPLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIER			2335 N	ORTH MADISON AVENUE			
	ONE WOODS			L	SON, IN46011			
(X4) ID	1	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	I '	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG	during the hours of 10p-6am	4-	DATE	
					ensure no resident is locked	ιο		
	On 7/15/2011 at	<i>'</i>			outside.			
		ovided a copy of the			The nursing staff will check all	3		
	incident report w	which was sent to the			entrance/exit doors every 2 hou			
	ISDH (Indiana S	State Department of			during the hours of 10p-6am. T	The		
	Health) on 07/11	/2011. The incident			charge nurse is responsible for			
	occurred on 07/1	0/2011 into 07/11/2011.			completing the census sheet even			
					night at midnight and will ensu- all residents are accounted for o			
	The brief descrip	otion of the incident			the nightly census check.	iui iiig		
	1				HOW THE CORRECTIVE			
	indicated: "At 9PM on 07/10/11, (names of Residents A and B) walked out the				ACTION(S) WILL BE			
	1	on the front porch glider.			MONITORED TO ENSURE			
	1				DEFICIENT PRACTICE WIL	L		
	1 -	rare of the front door			NOT RECUR, I.E., WHAT			
	I -	m the outside at 8PM. At			QUALITY ASSURANCE PROGRAM WILL BE PUT IN	JTO		
	· ·	of Residents A and B)			PLACE The Administrator, o			
	1 ^	ne back into the building			designee, will review the			
		he front door was locked.			surveillance video daily to er			
	(names of Resid	ents A and B) are			that staff are locking the doo	rs at		
	independent with	n nursing services			the designated time and to	ina		
	(dressing, ambul	ation, toileting, feeding			ensure that staff are conduct the 2 hour checks on the from	-		
	etc) but do have	dementia. They could			entrance. The Administrator			
	not figure out ho	ow to use the after hours			designee will correct any			
	I -	the front door nor could			discrepancy with that staff			
	1 ^	olution for notifying			member with a progressive			
	1	ey were locked out.			discipline. Upon 100% compliance over a 30-day			
		ent A) brought the front			consecutive time period, the			
	· ·	the foyer area (This is an			observations will decrease to			
	1 -	-			three (3) times a week. The			
	area between two sets of front doors which is enclosed) and they slept on the				Administrator will review the			
					findings of the observations			
	porch glider until 4AM. At 4AM, (Resident A) walked to the side of the building and knocked on (Name of				during the monthly Safety Committee Meeting and ther	n at		
					the quarterly QA meeting.	ιαι		
					The monitoring will continue u	ntil		
	1 ^	ment window. (Name of			there is 100% compliance for 6			
	Resident) then c	alled the police stating			•			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/09/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	00	07/15/2		
			B. WING			07/13/2	011	
NAME OF	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE			
KEYSTO	NE WOODS				ORTH MADISON AVENUE SON, IN46011			
(X4) ID		STATEMENT OF DEFICIENCIES		D I			(X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL	1	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	1	R LSC IDENTIFYING INFORMATION)		AG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE	
	someone was try	ring to break into her			consecutive months.			
	apartment. The	police called the facility						
	and notified the	staff of the call. The staff						
	went to investig	ate and discovered that						
	(Residents A and	d B) were in the foyer area						
	at 4:13 AM. (Na	ames of Residents A and						
	B) were not inju	red. (Names of Residents						
	A and B) then w							
	The immediate a	action taken was: "(Names						
	of Residents A a							
		was noted. The DON						
	1 * *	5AM on 07/11/2011. The						
		ras notified at 11AM on						
		e Administrator began an						
	1	determine the timeline of						
	"	estigation included review						
	1	apes of the front door.						
	1	n was concluded at 7PM						
	1	ove description of the						
	incident."	ove description of the						
	moraont.							
	1 ^	measures taken were: "On						
	1 *	otocol for locking the						
		evised to lock the front						
		nstead of 8PM. The						
	1 `	ents A and B) were placed						
		s from 10P-6A for						
		rification on 07/11/2011.						
		eing installed at all						
		o that a person can ring						
		summon staff (an after						
	1 -	ll ready located at each						
	entrance with th	e nurse's (sic) station						

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Event ID: QJSY11 Facility ID: 010409

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 07/15/2011			
	PROVIDER OR SUPPLIER		B. WING 07713/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 2335 NORTH MADISON AVENUE ANDERSON, IN46011					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
	number posted). front door stating 10PM and you ca you call the nurse exiting the front Resident A's clin on 7/15/2011 at a Resident A's diag not limited to, de Resident A's und Record" indicate cognitively impa decision-making ambulation and y form indicated ", resident at risk. There were no in according to this Resident A's nurse notation of this in after the incident Resident A had a Resident B's clin on 7/15/2011 at a Resident B's diag	A sign is posted on the gethe door is locked at an not get back in unless e's station for any one door." ical record was reviewed 10:55 A.M. gnoses included, but were ementia. ated "Elopement Risk de "yes" was checked for ired with poor skills, independent wandering aimlessly. The one YES placed the Proceed to interventions." terventions in place form. se's notes lacked any incident or an assessment incident or an assessment incident record was reviewed incident record was reviewed.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED - 07/15/2011				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2335 NORTH MADISON AVENUE ANDERSON, IN46011					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	Resident B's und Record" indicate cognitively imparate decision-making of dementia, indepain. The form in placed the reside interventions." The form. Resident B's nurrout notation of this in after the incident Resident B had a	ated "Elopement Risk d "yes" was checked for ired with poor skills,pertinent diagnosis ependent ambulation and ndicated " one YES nt at risk. Proceed to There were no place according to this se's notes lacked any ncident or an assessment						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED - 07/15/2011		
			B. WING			2011	
	PROVIDER OR SUPPLIER	R	2335 N	ADDRESS, CITY, STATE, ZIP CO ORTH MADISON AVENU SON, IN46011			
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR. (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A	OULD BE COMPLETION PPROPRIATE		
TAG	fence around the grounds. The frocounty road set be feet. There was the front doors we have been building an intervent for the feet of the	iew with the DON on 01 P.M., she indicated aning the residents) here in their own." She were five doors in the of them, except the front is on them. She indicated is on them. She indicated is used the front door and is she indicated the staff de doors and no one at 10 P.M. that night saw is at the front door. It is with the indicated is a single indicated is a single indicated in the residents are not in the residents are not because they are here.	TAG	DEFICIENCY)		DATE	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED 07/15/2011
			B. WING		07/15/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE ORTH MADISON AVENUE	
KEYSTO	NE WOODS			SON, IN46011	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE COMPLETION DATE
IAG) P.M., she indicated	IAG		DAIL
		g in Resident A and B's			
		licate if every two hour			
		ded or not needed.			
	Review the Resident Rights provided by				
the Administrator on 7/15/11 at 3:30 P.M.,					
	indicated "9. The resident has the right to				
be free from neglect"					
	This state residen	ntial tag relates to			
	complaint IN00093520.				
R0214	(a) An evaluation of	of the individual needs of	i i		
10211	each resident shal	I be initiated prior to			
		all be updated at least			
		upon a known substantial dent ' s condition, or more			
		nt 's or facility 's request. A			
		all evaluate the nursing			
	needs of the reside		D0214	R0214 WHAT CORRECTIVE	- 00/05/2011
		review and interview, the update the Service Plan	R0214	ACTION(S) WILL BE	08/05/2011
	of 2	update the Service Plan		ACCOMPLISHED FOR THO	.
		ired residents, who were		RESIDENTS FOUND TO HA	WE
		nbulatory themselves, to		BEEN AFFECTED BY THE DEFICIENT PRACTICE: Bot	h l
		nts were to be monitored		Residents A & B service plan	
	every 2 hours from 10 P.M. until 6 A.M.			were updated in writing on	
	-	a sample of 3 who were		07/15/2011 by the Administra HOW THE FACILITY WILL	ator.
		every 2 hours during the		IDENTIFY OTHER RESIDEN	NTS
night (Residents A		,		HAVING THE POTENTIAL T	ТО
	inght (Residents 71 and 15).			BE AFFECTED BY THE SAM	
	Findings include:			DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION	.
			<u> </u>		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
			B. WIN			07/15/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	₹			ORTH MADISON AVENUE		
KEYSTO	NE WOODS			1	SON, IN46011		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG		_	DATE
					WILL BE TAKEN: The servic plans for other residents ider		
	1. On 7/15/2011 at 11:00 A.M., the				as needing 2 hour checks for		
	Administrator pr	rovided a copy of the			reason, were reviewed to en		
	incident report v	which was sent to the			that the 2 hour check interve		
	ISDH (Indiana S	State Department of			was listed on their service pl	an by	
	`	/2011. The incident			the Administrator on 07/15/2		
	· ′	0/2011 into 07/11/2011.			WHAT MEASURES WILL BE		
	occurred on over	10,2011 IIIto 0,711,2011.			PUT INTO PLACE OR WHA		
	The build degening	ation of the incident			SYSTEMIC CHANGES THE FACILITY WILL MAKE TO		
	1	otion of the incident			ENSURE THAT THE DEFIC	FNT	
	1	PM on 07/10/11, (names			PRACTICE DOES NOT REC		
		nd B) walked out the			The Director of Nursing will b		
	front door to sit	on the front porch glider.			responsible for writing immed		
	They were unaw	are of the front door			updates on the service plan		
	being locked fro	m the outside at 8PM. At			ensure that the service plan		
	9:20PM (names	of Residents A and B)			kept current at all times. The		
	,	ne back into the building			Director of Nursing will notify resident and/or responsible p		
	1 ^	he front door was locked.			of the change in the service	-	
		lents A and B) are			The Administrator will review		
	· '	•			service plans semi-annually	and	
	_	h nursing services			print off revisions made to th		
		ation, toileting, feeding			service plan at that time. HO		
	· ·	dementia. They could			THE CORRECTIVE ACTION	I(S)	
	1 -	ow to use the after hours			WILL BE MONITORED TO ENSURE THE DEFICIENT		
	phone located by	the front door nor could			PRACTICE WILL NOT RECI	JR.	
	they process a so	olution for notifying			I.E., WHAT QUALITY	J. 1,	
	someone that the	ey were locked out.			ASSURANCE PROGRAM W	/ILL	
		ent A) brought the front			BE PUT INTO PLACE The		
	`	the foyer area (This is an			Administrator will review the		
	area between two sets of front doors				service plans weekly to verify		
					immediate updates on service plans are visible on the servi		
	which is enclosed) and they slept on the				plan. Findings from the wee		
	porch glider until 4AM. At 4AM,				review will be discussed duri	-	
	(Resident A) walked to the side of the				the weekly Department Mana		
	building and knocked on (Name of				Meeting and then quarterly d	uring	
	Resident)'s apart	ment window. (Name of			the Quarterly Assurance Med	eting.	
	Resident) then c	alled the police stating			The monitoring will continue		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
			B. WING			07/15/2	011
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUFFLIER			2335 N	ORTH MADISON AVENUE		
	NE WOODS				SON, IN46011		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	-	IAG	indefinitely as this is our policy		DATE
	l	ing to break into her			indefinitely as this is our poncy	'.	
	. ^ .	police called the facility					
	and notified the staff of the call. The staff						
	went to investigate and discovered that						
	(Residents A and B) were in the foyer area						
	at 4:13 AM. (Names of Residents A and						
	B) were not injured. (Names of Residents						
	A and B) then went to their apartment."						
		-					
	The preventive n						
	The (Name of Residents A and B) were						
	`	checks from 10P-6A for					
	whereabouts veri						
	07/11/2011"	incation on					
	0//11/2011						
	Pacident A's clin	ical record was reviewed					
	on 7/15/2011 at 1						
	1	gnoses included, but were					
	not limited to, de						
	Resident A had a	guardian.					
	Pasidant A's Sam	vice Plan lacked every 2					
		1 10 P.M. until 6 A.M.					
	Hour checks from	I IO F.M. UIIII O A.M.					
	 Resident B's clin	ical record was reviewed					
	on 7/15/2011 at 1						
		gnoses included, but were					
	· `	•					
	· ·	ementia and confusion.					
	Resident B had a	guardian.					
	Resident B's Serv	vice Plan lacked every 2					
		1 10 P.M. until 6 A.M.					
	nour cheeks iron	i io i .ivi, unui U A.ivi.					
	During an intervi	iew with the DON on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
			B. WING	,		07/15/2	011
	PROVIDER OR SUPPLIER		23	35 NC	DRESS, CITY, STATE, ZIP CODE DRTH MADISON AVENUE SON, IN46011		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R0349	there was nothing assessment to incohecks were need. This state resider complaint IN000 (a) The facility must on each resident. maintained under employee of the faresponsibility. The (1) Complete. (2) Accurately doc (3) Readily access (4) Systematically Based on record facility failed to record the incide had been locked hours at night an assessment of the re-entered the fact reviewed for clin of 3 (Residents Administrator princident report w ISDH (Indiana S Health) on 07/11	st maintain clinical records These records must be the supervision of an acility designated with that records must be as follows: umented. sible. organized. review and interview, the document in the clinical nt of 2 residents who out of the facility for 6 d then to document the e residents when they had cility for 2 of 3 residents ical records in a sample A and B).	R0349		R0349 WHAT CORRECTIVE ACTION(S) WILL BE ACCOMPLISHED FOR THO RESIDENTS FOUND TO HABEEN AFFECTED BY THE DEFICIENT PRACTICE: The nurses were inserviced on the Incident/Accident Policy on 08/02/2011. The inservice included discussion and definitions of incidents so the nurses can identify what constitutes an incident. The Incident/Accident policy direct the nurse to complete an incident which guides the nurse perform specific tasks related the incident which include are assessment, vitals, notificating family & physician. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE	oSE AVE ene at the cts ident e to d to n on of E	08/05/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
			B. WIN			07/15/2	011
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEI	₹		1	ORTH MADISON AVENUE		
KEYSTO	NE WOODS			1	RSON, IN46011		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	-	TAG			DATE
					AFFECTED BY THE SAME	,	
	The brief descrip	otion of the incident			DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION		
	indicated: "At 91	PM on 07/10/11, (names			WILL BE TAKEN: The nurse		
	of Residents A a	nd B) walked out the			were inserviced on the	3	
		on the front porch glider.			Incident/Accident Policy on		
		• •			08/02/2011. The inservice		
	1	vare of the front door			included discussion and		
	_	m the outside at 8PM. At			definitions of incidents so that	at the	
	`	of Residents A and B)			nurses can identify what		
	attempted to cor	ne back into the building			constitutes an incident. The		
	and discovered the front door was locked.				Incident/Accident policy dire		
	(Names of Residents A and B) are				the nurse to complete an inc		
	`	h nursing services			report which guides the nurs perform specific tasks relate		
	_	lation, toileting, feeding			the incident which include ar		
	I ' -				assessment, vitals, notification		
	1	e dementia. They could			family & physician. WHAT	311 31	
	_	ow to use the after hours			MEASURES WILL BE PUT I	NTO	
	phone located by	y the front door nor could			PLACE OR WHAT SYSTEM	IC	
	they process a so	olution for notifying			CHANGES THE FACILITY V	VILL	
	someone that the	ey were locked out.			MAKE TO ENSURE THAT T		
		ent A) brought the front			DEFICIENT PRACTICE DO		
	,	the foyer area (This is an			NOT RECUR: The nurses w	ere	
		o sets of front doors			inserviced on the		
					Incident/Accident Policy on 08/02/2011. The inservice		
		ed) and they slept on the			included discussion and		
	1 ^	il 4AM. At 4AM,			definitions of incidents so that	at the	
	(Resident A) wa	lked to the side of the			nurses can identify what		
	building and known	ocked on (Name of			constitutes an incident. The		
	_	tment window. (Name of			Incident/Accident policy dire		
		alled the police stating			the nurse to complete an inc		
	· /	ving to break into her			report which guides the nurs		
	1	•			perform specific tasks relate		
	_	police called the facility			the incident which include ar		
		staff of the call. The staff			assessment, vitals, notification family & physician. HOW TH		
	went to investiga	ate and discovered that			CORRECTIVE ACTION(S) V		
	(Residents A and B) were in the foyer area				BE MONITORED TO ENSU		
	at 4:13 AM. (Names of Residents A and				THE DEFICIENT PRACTICE		
	`				WILL NOT RECUR, I.E., WH		
	B) were not injured. (Names of Residents				<u> </u>		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		A. BUILDING 00		COMPLETED		
			B. WING			07/15/2011		
			STREET ADDRESS, CITY, STATE, ZIP CODE					
NAME OF PROVIDER OR SUPPLIER				2335 NORTH MADISON AVENUE				
KEYSTONE WOODS				ANDERSON, IN46011				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG			DATE	
	A and B) then went to their apartment." Resident A's clinical record was reviewed on 7/15/2011 at 10:55 A.M.				QUALITY ASSURANCE			
				PROGRAM WILL BE PUT INT PLACE The Director of Nursing or designee will review the				
						ing,		
	Resident A's diagnoses included, but were not limited to, dementia.			24-report sheets daily to ensure that all incidents are processed				
					according to the Incident/Accident			
					Policy. The Director of Nursing,			
	Resident A's nurse's notes lacked any notation of this incident or an assessment				or designee will review the			
					resident's medical chart following			
					the submission of an Incident			
	after the incident.				Report Form to ensure that the			
					appropriate documentation was			
					completed in that medical chart. The Director of Nursing will make a notation on the Incident Report Form once the review is			
	Resident B's clinical record was reviewed							
	on 7/15/2011 at 11:08 A.M. Resident B's diagnoses included, but were not limited to, dementia and confusion.							
					completed. The findings of the review will be reviewed monthly			
					during the Safety Committe			
	Resident B's nurs	se's notes lacked any			Meeting and then Quarterly			
		ncident or an assessment			during the Quality Assurance	.		
					Meeting.			
	after the incident.		The mor		The monitoring for this will cor	ntinue		
					indefinitely as this is our policy			
	During an interview with the DON on 7/15/2011 at 12:01 P.M., she indicated the staff who were on duty that night were supposed to chart what had happened. This state residential tag refers to complaint IN00093520.							